CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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CHAPTER II
PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING PROVIDER

A participating hospice provider is a hospice which has been certified by the Virginia Department of Health (VDH) and by Title XVIII (Medicare) as a provider of hospice services and which has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

PROVIDER ENROLLMENT

A hospice must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. Billing forms will not be issued to providers who do not sign a participation agreement with DMAS. In order to become a Medicaid-certified provider of services, the hospice can request a participation agreement by writing:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

A copy of the Provider Participation Agreement is provided in the Exhibits section at the end of Chapter II.

Upon completion of the enrollment process, a seven-digit provider number will be assigned to each provider. This number must be used on all claims and correspondence submitted to Medicaid.

CONDITIONS OF PARTICIPATION

Providers of hospice services must comply with all of the following conditions of participation:

<u>Services</u>

- Employees who provide hospice services must be licensed, certified, or registered in accordance with applicable federal or state laws;

- The hospice must designate an interdisciplinary team composed of a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or

other counselor who are employees of the hospice and who provide or supervise the care and services offered by the hospice.

- The interdisciplinary team is responsible for participation in the establishment of the plan of care, provision or supervision of hospice care and services, periodic review and updating of the plan of care for each individual receiving hospice care, and establishment of policies governing the day-to-day provision of hospice care and services.

- The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

- A written plan of care must be established and maintained for each individual admitted to the hospice program, and the care provided to an individual must be in accordance with the plan.

- The hospice must make nursing services, physician services, drugs, and biologicals routinely available on a 24-hour basis. The hospice must make all other covered services available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of the terminal illness and related conditions.

- All services must be provided in a manner consistent with accepted standards of practice.

Professional Management

- A hospice must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the hospice's total operation. The governing body must designate an individual who is responsible for the day-to-day management of the hospice program.

- The medical director must be a hospice employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice's patient care program.

- A hospice may arrange for another individual or entity to furnish services to the hospice's patients. If services are provided under contractual arrangement, the hospice must:

  1) assure the continuity of patient/family care in home, outpatient, and inpatient settings, and

  2) have a legally binding written agreement for the provision of arranged services which includes the identification of the services to be provided; a stipulation that services may be provided only with the express authorization of the hospice; the manner in which the contracted services are coordinated, supervised, and evaluated by the hospice; the delineation of the roles of the hospice and the contractor in the admission process, patient/family

assessment, and the interdisciplinary group care conferences; requirements for documenting that services are furnished in accordance with the agreement; and the qualifications of the personnel providing the services.

- The hospice must retain professional management responsibility for contracted services and ensure that they are furnished in a safe and effective manner by qualified persons and in accordance with the patient's plan of care.

- The hospice must ensure that inpatient care is furnished only in a facility that has a legally binding written agreement with the hospice. The hospice must furnish the contractor with a copy of the patient's plan of care and specify the inpatient services to be furnished. The inpatient provider must have established policies that are consistent with those of the hospice and must agree to abide by the patient care protocols established by the hospice for its patients. The medical record must include documentation of all inpatient services and events, and a discharge summary must be provided to the hospice. The agreement must specify the party responsible for the implementation of the provisions of the agreement. The hospice retains responsibility for appropriate hospice care training of the personnel who provide care under the agreement.

Quality Assurance

- A hospice must conduct an ongoing, comprehensive, integrated, self-assessment of the quality and appropriateness of care provided, including inpatient care, home care, and care provided under contractual arrangements. These findings are used by the hospice to correct identified problems and to revise hospice policies, if necessary.

- Those responsible for quality assurance must implement and report on activities and mechanisms for monitoring the quality of patient care, identify and resolve problems, and make suggestions for improving patient care.

DOCUMENTATION REQUIREMENTS

Medical records must substantiate the services billed to DMAS by the hospice. The medical records must be accurate and appropriate and must include the following:

- the initial and subsequent assessments
- the plan of care
- identification data
- authorization forms
- pertinent medical history, diagnoses, and prognosis
- complete documentation of all services and events (including evaluations, treatments, progress notes, etc.)
- certification statements of the terminal illness of all recipients
- election statements from each recipient

The record must identify the patient on each page. Entries must be signed and dated

(month, day, and year) by the author, followed by professional title. Care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider. All services provided, as well as the plan of care, must be entered in the record.

Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no reimbursement will be provided.

PARTICIPATION REQUIREMENTS

Providers approved for participation in Medicaid must perform the following activities as well as any other specified by DMAS:

- Immediately notify First Health Services' Provider Enrollment Unit (FHS/PEU) in writing whenever there is a change in any of the information that the provider previously submitted to the Department;
- Ensure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed;
- Ensure the recipient's freedom to reject medical care and treatment;
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin;
- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;
- Not require, as a precondition for admission or continued stay, any period of private pay or a deposit from the patient or any other party;
- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;
- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public;

- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;

- Accept as payment in full the amount established by DMAS to be the reasonable cost or the maximum allowable cost. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the State. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. A provider may not bill DMAS or recipients for broken or missed appointments.

  For example: If a third party payer reimburses $5.00 of an $8.00 charge, and Medicaid's allowance is $5.00, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3.00 difference.

- Accept assignment of Medicare benefits for eligible Medicaid recipients;

- Use program-designated billing forms for submission of charges;

- Maintain and retain the business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. In general, such records must be retained for a period of not less than five years from the date of service or as provided by applicable State laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception is resolved;

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;

- Disclose, as requested by the program, all financial, beneficial ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance;

- Hold confidential and use for authorized DMAS purposes only, all medical assistance information regarding recipients. A provider shall disclose information in his possession only when the information is to be used in conjunction with a claim for health benefits or when the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 U. S. C. §794), provides that no disabled individual shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, all Medicaid providers are responsible for making provision for handicapped individuals in their program activities.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

REQUIREMENTS OF THE CIVIL RIGHTS ACT OF 1964

All providers of care and suppliers of services under the contract with DMAS must comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.

FRAUD

Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or his agent to obtain or seek direct or indirect payment, gain, or an item of value for services rendered or supposedly rendered to recipients under Medicaid. A provider participation agreement will be terminated or denied in cases where a provider is found guilty of fraud.

Investigation of allegations of provider fraud is the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel in this unit for investigative purposes.

REVIEW AND EVALUATION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of provider practices and of utilization of services by recipients. This function is handled by the Virginia Medical Assistance Program's Division of Program Compliance.

Computerized exception reports for providers are developed by comparing an individual provider's billing activities with those of the provider peer group. Exception reports for

recipients are developed by comparing individual recipient's medical services utilization with those of the recipient peer group. For recipients and providers who exceed the peer group averages by at least two standard deviations, an exception report for this activity is generated.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

The use of statistical sampling is recognized as a valid basis for findings of fact in the context of Medicaid reimbursement. DMAS utilizes a scientific random sample of paid claims for a 15-month audit period to calculate any excess payment. The number and amount of invalid dollars paid in the audit sample is compared to the total number and amount of dollars paid for the same time period, and the total amount of the overpayment is estimated from this sample.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to policy, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, Medicaid may limit, suspend, or terminate the provider's participation agreement.

Providers selected for review will be contacted directly by DMAS personnel with detailed instructions. This will also apply when information is requested about a recipient or when a recipient is restricted to the physician and/or pharmacy of his choice because of misutilization of Medicaid services.

TERMINATION OF PROVIDER PARTICIPATION

The participation agreement is not time-limited, and will only expire upon the lapse or loss of licensure or certification of the provider, action taken by DMAS to meet the requirements of the agreement, regulations or law, inactive participation by the provider (no billing within 36 months), or resignation by the provider. DMAS will request a copy of the renewed licensure/certification prior to its expiration.

A participating provider may terminate his participation in Medicaid at any time. Thirty (30) days' written notification of voluntary termination must be provided to the Director, Department of Medical Assistance Services.

DMAS may terminate a provider from participation upon thirty (30) days' written notification. Such action precludes further payment by DMAS for services provided to recipients subsequent to the date specified in the termination notice.

Section 32.1-325(C) of the Code of Virginia mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when DMAS takes adverse action such as termination or suspension of the provider agreement or denial of payment for services rendered based on utilization review decisions.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have a 30 day notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§ 9-6.14:1 through 9-6.14:25 of the Code of Virginia)(the APA) and the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review decisions. State-operated provider means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, DMAS Director review, and Secretarial review. First, the state-operated provider will submit to the appropriate DMAS Division written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable law and regulations. The Division Director will consider any recommendation of his or her designee and render a decision.

A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director has the authority to take whatever measures he deems appropriate to resolve the dispute.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated

provider, within 30 days after receipt of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources or any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries will be final.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information.

A provider may not wish to receive provider manuals or Medicaid memoranda because he or she has access to the publications as a part of a group practice. To suppress the receipt of this information, the First Health Provider Enrollment Unit requires the provider to complete the Mail Suppression Form and return it to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Upon receipt of the completed form, FH-PEU will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.

EXHIBITS

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Provider Participation Agreement 1

Mailing Suspension Request Form 2

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

Hospice Care Participation Agreement

If re-enrolling, enter **Medicaid** Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:

PAYMENT/CORRESPONDENCE ADDRESS

NAME

ATTENTION

ADDR LINE 1

ADDR LINE 2

CITY, STATE, ZIP

PHYSICAL ADDRESS
(*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)

on this _____day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider is currently licensed and certified under applicable laws of this state as of _____ (Date) and has been fully certified for participation with Title XVIII (Medicare) of Public Law 89-97.**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his medical or physical handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.§ 794) in VMAP.**
3. **The applicant agrees to keep such records as VMAP determines necessary. The applicant will furnish VMAP, on request, information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General, or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the applicant agrees not to submit additional charges to the recipient for services covered under Medicaid. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Medicaid recipient for any service provided under Medicaid is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.**
7. **Payment by VMAP at its established rates for the services involved shall constitute full payment to the provider. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.**
8. **The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**

11. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For Provider of Services:

For First Health's use *only*

Director, Division of Program Operations Date

Original Signature of Administrator **Date**

Title

_____City OR _____County of _____

IRS Name (required)

IRS Identification Number **(Area Code) Telephone Number**

Mail or fax **one** completed **original** agreement to:

First Health - VMAP-Provider Enrollment Unit
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-7027

Medicare Carrier and Vendor Number (if applicable)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

MAILING SUSPENSION REQUEST

Medicaid Provider Number: _____

Provider Name: _____

I do not wish to receive Medicaid memos, forms or manual updates under the Medicaid provider number given above because the information is available to me under Medicaid provider number

Provider Signature: _____

Date: _____

Please return this completed form to:

First Health Provider Enrollment Unit
P.O. Box 26803
Richmond, VA 23261-6803